MARIJUANA REGISTRY
REGISTERED PATIENT APPLICATION INSTRUCTIONS

1. **BE SURE TO CAREFULLY READ THE PROGRAM INFORMATION WHICH HAS BEEN PROVIDED WITH THIS APPLICATION AND IS AVAILABLE ON OUR WEB SITE AT WWW.DPS.STATE.VT.US.**

2. Complete the Application Form in ink. Have your physician complete the Section that is designated "*PHYSICIAN'S MEDICAL VERIFICATION FORM*.**"** Have your physician return the form to you when it is completed. Do **NOT** have your physician return the form to the Registry.

3. Once the application is completed contact a notary public to notarize your signature.

4. Arrange to have your digital photograph taken. The digital photograph will be used for your Registry Identification Card. You can use your own digital camera or have a digital photograph taken by a studio/store that takes passport photos. **Make sure that your digital photograph is taken using a .jpg format.** Have the photo copied to a **floppy disk or CD**. Label the disk or CD with your name and date of birth and include it with your application.

5. Enclose a check or money order for $50 (non-refundable) made payable to the Department of Public Safety. The Registry cannot accept cash, credit cards, or installment payments.

6. Mail the completed application with your check and digital photograph to:

   Marijuana Registry
   Department of Public Safety
   103 South Main Street
   Waterbury, Vermont 05671

7. **Your application cannot be processed by the Registry until it is complete. A complete application includes the completed 5-page application and the 3-page physician's medical verification forms, a check for $50, (non-refundable) and a digital photograph.**

8. Please call the Registry at 802-241-5115 if you have any questions.

DO NOT DETACH PAGES

APPLICATION FORM - REGISTERED PATIENT MARIJUANA REGISTRY

Instructions: Please complete all sections labeled **"Required."** Sections labeled **"Optional"** need to be completed only if they apply to your case. Please type or print your responses on this form **in ink**. A downloadable version of this form may be found at www.dps.state.vt.us/cjs/marijuana/htm. If you have any questions regarding this form please call 802-241-5115.

APPLICANT INFORMATION - REQUIRED

☐ Initial Application ☐ Renewal Application	**If renewal application** - your ID Number		
Name	Last	First	Middle
Mailing Address	Number / Street/P.O. Box		
	City	State	Zip Code
Telephone	Home	Work	
Physical Address	(Only if different than mailing address.)		
Date of Birth		**VT Driver's License or Non-Driver ID #**	
E-Mail Address (Optional)			

REGISTERED CAREGIVER - OPTIONAL

"Registered caregiver" means a person who is at least 21 years old who has never been convicted of a drug-related crime and who has agreed to undertake responsibility for managing the well-being of a registered patient with respect to the use of marijuana for symptom relief.

My Registered Caregiver will be:

Name	Last	First	Middle
Mailing Address	Number / Street/P.O. Box		
	City	State	Zip Code
Telephone	Home	Work	
Physical Address	(Only if different than mailing address.)		
Date of Birth		**VT Driver's License or Non-Driver ID #**	
E-Mail Address (Optional)			

SECURE INDOOR FACILITY - OPTIONAL

A registered patient or registered caregiver who elects to grow marijuana to be used for symptom relief by the patient may do so only if the marijuana is cultivated in a single, secure indoor facility as defined in 18 VSA § 4475(8). **My physical secure indoor facility address:**

Street Address	Number	Street
	City	State

If you are using a room in the house, please describe the location of the room:

MARIJUANA REGISTRY PROGRAM ACKNOWLEDGEMENTS	
The registering patient must <u>initial</u> each paragraph to acknowledge receipt of the information and their understanding of the information.	
	I understand that if my application is approved, my registration is valid for one year. I must renew my registration every year by submitting another application and paying a $50 fee.
	I understand that if I am notified of a denial I have 7 days to appeal this decision from the time I receive notice of the denial. I understand that the review will be limited to the information submitted with my original application and consultation with my treating physician. All records relating to the appeal shall be kept confidential. An appeal shall be decided by a majority vote of the members of the board.
	I understand that if my application is approved and I elect to grow marijuana to be used for symptom relief, I may do so only if the marijuana is cultivated in the secure indoor facility identified in this application.
	I understand that if my application is approved and I am in possession of a Marijuana registration card, I may not possess between myself and my registered caregiver more than two mature marijuana plants, seven immature plants, and two ounces of usable marijuana.
	I understand that even if my application is approved I may only use marijuana for purposes of symptom relief as defined in 18 V.S.A. § 4472(10).
	I understand that even if my application is approved, I may not use marijuana in public, while operating a motorized vehicle, in a workplace or place of employment, while operating heavy machinery or handling a dangerous instrumentality, or in a manner that endangers the health or well-being of another person.
	I understand that if my application is approved, I may not transport marijuana in public unless it is secured in a locked container.
	I understand that a law enforcement officer who finds marijuana or paraphernalia in public from a registered patient or registered caregiver which is not properly secured in a locked container shall not be required to return the marijuana or paraphernalia. A law enforcement officer who finds marijuana being cultivated by a registered patient or registered caregiver, which is not in the single, secure indoor facility identified in this application, shall not be required to return the marijuana or growing paraphernalia to the registered patient or registered caregiver.
	I have instructed my registered caregiver that in the event of my death the Marijuana Registry must be contacted within 72 hours. The caregiver must return to the Department of Public Safety any marijuana or marijuana plants that may have been in our possession for disposal.
	I understand that if I do not have a caregiver that I will instruct my next of kin to notify the Marijuana Registry within 72 hours of my death and request the Department of Public Safety to retrieve such marijuana and/or marijuana plants for disposal.
	I understand that any person who knowingly gives to any law enforcement officer false information to avoid arrest or prosecution, or to assist another in avoiding arrest or prosecution, shall be imprisoned for not more than one year or fined not more than $1,000.00 or both. This penalty shall be in addition to any other penalties that may apply for the possession or use of marijuana.

REGISTERED PATIENT'S CERTIFICATION OF DEBILITATING MEDICAL CONDITION

This section is to be completed by a registered patient who does **not** have a "bona fide physician-patient relationship".

Definitions:

"Bona fide physician-patient relationship" means :

A treating or consulting relationship of not less than six months duration, in the course of which a physician has completed a full assessment of the registered patient's medical history and current medical condition, including a personal physical examination.

"Debilitating medical condition" means:

(A) Cancer, acquired immune deficiency syndrome, positive status for human immunodeficiency virus, multiple sclerosis, or the treatment of these conditions if the disease or the treatment results in severe, persistent and intractable symptoms; or

(B) A disease , medical condition, or its treatment that is chronic, debilitating and produces severe persistent and one or more of the following intractable symptoms: cachexia or wasting syndrome, severe pain, severe nausea or seizures; and

(C) Reasonable medical efforts have been made over a reasonable amount of time without success to relieve the symptoms.

Please initial the following statements if they apply to you:

	My "debilitating medical condition" as defined above is of recent or sudden onset.
	I have not had a previous physician who is able to verify the nature of the disease and its symptoms.

If you initialed either of the above statements you must attach to this application a copy of relevant portions of your medical records sufficient to establish that you have a debilitating medical condition as defined above.

MARIJUANA REGISTRY PROGRAM

I _____, swear under oath that I have read and understand the above Marijuana Registry Program Acknowledgements and that by my signature I acknowledge that the information I have provided in this application is true and accurate.

TO BE COMPLETED BY A NOTARY

_____ personally appeared before me and having
(Name of Patient)
satisfactorily identified himself/herself, being duly sworn, says that this application is true and accurate. It is subscribed and sworn to before me on

this _____day of _____,_____ _____
Applicant

_____
Parent or Guardian if applicant is not 18

_____ _____
Notary Public Date

If the applicant is under 18 please provide the following information for the parent or legal guardian.

Name	Last		First	Middle
Mailing Address	Number	Street/P.O. Box		
	City		State	Zip Code

MAIL COMPLETED FORM TO:

Marijuana Registry
Vermont Criminal Information Center
Vermont Department of Public Safety
103 South Main Street
Waterbury, VT 05671

FOR ADMINISTRATIVE PURPOSES ONLY	
Date Application Received	Date Application was Complete
Identification Number	Staff